

SENT VIA EMAIL OR FAX ON
Sep/13/2010

Applied Resolutions LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/09/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopic eval of shoulder joint with open Neer-Mumford procedure to decompress the osseous outlet and probable repair of persistent or repeat tear of the rotator cuff

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified in Orthopaedic Surgery with Fellowship Training in Upper Extremities

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 7/19/10 and 7/30/10

MRI 6/8/10

Health & Medical Practice 7/8/10

Center of Texas 1/25/10

Dr. 4/28/09

PATIENT CLINICAL HISTORY SUMMARY

The patient previously underwent an open distal clavicle resection and rotator cuff repair. The patient has persistent pain in the shoulder, particularly with overhead activity. Repeat MRI scan did not show any full-thickness defect in the rotator cuff. However, significant artifact was noted deep to metallic anchors. The MRI scan was a non-contrast study. Some fluid is noted in the subacromial space. The patient has had two subacromial anesthetic and steroid injections with temporary relief of her symptoms. Because of persistent symptoms, the surgeon has recommended arthroscopic evaluation of the shoulder with open decompression and possible rotator cuff repair. This has been denied by the insurance company as medically necessary. The 1st denial was based on the fact that the request for surgery did not come with any clinical notes. The 2nd denial was by an orthopedic surgeon who stated that the patient did not meet the criteria for rotator cuff repair due to the lack of findings on the MRI scan.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The insurance company denials are inappropriate in this case. The criteria used to deny the case by the 2nd reviewer do not apply to revision operations. The patient has responded temporarily to subacromial injections, which confirmed that the patient's pain is still coming from the subacromial space. The metallic artifact make the MRI scan unreliable. The patient

has failed lower levels of care and the request by the surgeon is reasonable and necessary at this point.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)